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Red Lake Indian reservation, from the amount determined to be payable to a county pursuant to this section.
HIST:1975 c 361 s 1; 1984 c 654 art 5 s 58; 1985 c 248 s 70

256.966 MEDICAL CARE PAYMENTS; ALLOWABLE INCREASE IN COST PER SERVICE UNIT.

Subdivision 1. In general. For the biennium ending June 30, 1985, the annual increase in the cost per service unit paid to any vendor under medical assistance and general assistance medical care shall not exceed five percent, except that the five percent annual increase limitation applied to vendors under this subdivision does not apply to nursing homes licensed under chapter 144A or boarding care homes licensed under sections 144.50 to 144.56. The estimated acquisition cost of prescription drug ingredients is not subject to the five percent increase limit, any general state payment reduction, or cost limitation described in this section, except as required under federal law or regulation. For vendors enrolled in the general assistance medical care program, the annual increase in cost per service unit allowable during state fiscal year 1984 shall not exceed five percent. The basis for measuring growth shall be the cost per service unit that would have been reimbursable in state fiscal year 1983 if payments had not been ratably reduced and if payments had been based on the 50th percentile of usual and customary billings for medical assistance in 1978. The increase in cost per service unit allowable for vendors in the general assistance medical care program during state fiscal year 1985 shall not exceed five percent. The basis for measuring growth shall be state fiscal year 1984.

Subd. 2. Repealed, 1987 c 403 art 2 s 164
HIST:1981 c 360 art 2 s 1; 1982 c 640 s 9; 1983 c 312 art 5 s 6; 1984 c 580 s 2; 1984 c 654 art 5 s 58

256.967 Repealed, 1Sp1985 c 9 art 2 s 104

256.968 Repealed, 1987 c 299 s 25

256.969 INPATIENT HOSPITALS.

Subdivision 1. Annual cost index. The commissioner of human services shall develop a prospective payment system for inpatient hospital service under the medical assistance and general assistance medical care programs. Rates established for licensed hospitals for rate years beginning during the fiscal biennium ending June 30, 1987, shall not exceed an annual hospital cost index for the final rate allowed to the hospital for the preceding year not to exceed five percent in any event. The annual hospital cost index shall be obtained from an independent source representing a statewide average of inflation estimates determined for expense categories to include salaries, employee benefits, medical fees, raw food, medical supplies, pharmaceuticals, utilities, repairs and maintenance, insurance other than malpractice insurance, and other applicable expenses

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as determined by the commissioner. The index shall reflect the regional differences within the state and include a one percent increase to reflect changes in technology. The annual hospital cost index shall be published 30 days before the start of each calendar quarter and shall be applicable to all hospitals whose fiscal years start on or during the calendar quarter.

Subd. 2. **Rates for inpatient hospitals.** On July 1, 1984, the commissioner shall begin to utilize to the extent possible existing classification systems, including Medicare. The commissioner may incorporate the grouping of hospitals with similar characteristics for uniform rates upon the development and implementation of the diagnostic classification system. Prior to implementation of the diagnostic classification system, the commissioner shall report the proposed grouping of hospitals to the senate health and human services committee and the house health and welfare committee. The computation of the base year cost per admission and the computation of the relative values of the diagnostic categories must include identified outlier cases and their weighted costs up to the point that they become outlier cases, but must exclude costs and days beyond that point. Claims paid for care provided on or after August 1, 1985, shall be adjusted to reflect a recomputation of rates, unless disapproved by the federal Health Care Financing Administration. The state shall pay the state share of the adjustment for care provided on or after August 1, 1985, up to and including June 30, 1987, whether or not the adjustment is approved by the federal Health Care Financing Administration. The commissioner may reconstitute the diagnostic categories to reflect actual hospital practices, the specific character of specialty hospitals, or to reduce variances within the diagnostic categories after notice in the State Register and a 30-day comment period. After May 1, 1986, acute care hospital billings under the medical assistance and general assistance medical care programs must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments with inpatient hospitals that have individual patient lengths of stay in excess of 30 days regardless of diagnosis-related group. For purposes of establishing interim rates, the commissioner is exempt from the requirements of chapter 14. Medical assistance and general assistance medical care reimbursement for treatment of mental illness shall be reimbursed based upon diagnosis classifications. The commissioner may selectively contract with hospitals for services within the diagnostic classifications relating to mental illness and chemical dependency under competitive bidding when reasonable geographic access by recipients can be assured. No physician shall be denied the privilege of treating a recipient required to utilize a hospital under contract with the commissioner, as long as the physician meets credentialing standards of the individual hospital. Effective July 1, 1988, the commissioner shall limit the annual

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increase in pass-through cost payments for depreciation, rents and leases, and interest expense to the annual growth in the consumer price index for all urban consumers (CPI-U). When computing budgeted pass-through cost payments, the commissioner shall use the annual increase in the CPI-U forecasted by Data Resources, Inc. consistent with the quarter of the hospital's fiscal year end. In final settlement of pass-through cost payments, the commissioner shall use the CPI-U for the month in which the hospital's fiscal year ends compared to the same month one year earlier.

Subd. 2a. Audit adjustments to inpatient hospital rates. Inpatient hospital rates established under subdivision 2 using 1981 historical medicare cost-report data may be adjusted based on the findings of audits of hospital billings and patient records performed by the commissioner that identify billings for services that were not delivered or never ordered. The audit findings may be based on a statistically valid sample of billings of the hospital. After the audits are complete, the commissioner shall adjust rates paid in subsequent years to reflect the audit findings and recover payments in excess of the adjusted rates or reimburse hospitals when audit findings indicate that underpayments were made to the hospital.

Subd. 3. Special considerations. (a) In determining the rate the commissioner of human services will take into consideration whether the following circumstances exist:

(1) minimal medical assistance and general assistance medical care utilization;

(2) unusual length of stay experience; and

(3) disproportionate numbers of low-income patients served.

(b) To the extent of available appropriations, the commissioner shall provide supplemental grants directly to a hospital described in section 256B.031, subdivision 10, paragraph (a), that receives medical assistance payments through a county-managed health plan that serves only residents of the county. The payments must be designed to compensate for actuarially demonstrated higher health care costs within the county, for the population served by the plan, that are not reflected in the plan's rates under section 256B.031, subdivision 4.

Subd. 4. Appeals board. An appeals board shall be established for purposes of hearing reports for changes in the rate per admission. The appeals board shall consist of two public representatives, two representatives of the hospital industry, and one representative of the business or consumer community. The appeals board shall advise the commissioner on adjustments to hospital rates under this section.

Subd. 5. Appeal rights. Nothing in this section supersedes the contested case provisions of chapter 14, the administrative procedure act.

Subd. 6. Rules. The commissioner of human services shall promulgate emergency and permanent rules to implement a

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system of prospective payment for inpatient hospital services pursuant to chapter 14, the administrative procedure act. Notwithstanding section 14.53, emergency rule authority authorized by Laws 1983, chapter 312, article 5, section 9, subdivision 6, shall extend to August 1, 1985.
HIST:1983 c 312 art 5 s 9; 1984 c 534 s 20,21; 1984 c 640 s 32; 1984 c 654 art 5 s 58; 1Sp1985 c 9 art 2 s 34-36; 1986 c 420 s 6; 1Sp1986 c 3 art 2 s 51; 1987 c 403 art 2 s 64,65

256.97 Repealed, 1957 c 737 s 2

256.971 SERVICES FOR DEAF.

The commissioner of human services shall provide such services for the deaf and hard of hearing in the state as will best promote their personal, economic and social well being. The commissioner shall maintain a register of all such persons, with such information as the commissioner deems necessary to improve services for them. The commissioner shall gather and disseminate information relating to the causes of deafness , collect statistics on the deaf and ascertain what trades or occupations are most suitable for them, and use best efforts to aid them in securing vocational rehabilitation and employment, through cooperation with other agencies, both public and private.
HIST:1957 c 737 s 1; 1984 c 654 art 5 s 58; 1986 c 444

256.974 OFFICE OF OMBUDSMAN FOR OLDER MINNESOTANS; LOCAL PROGRAMS.

The ombudsman for older Minnesotans serves in the classified service under section 256.01, subdivision 7, in an office within the Minnesota board on aging that incorporates the long-term care ombudsman program required by the Older Americans Act, Public Law Number 98-456, United States Code, title 42, section 3027(a)(12), and established within the Minnesota board on aging. The Minnesota board on aging may make grants to local programs or area agencies on aging for the provision of ombudsman services to clients in county or multicounty areas. Individuals providing local ombudsman services must be qualified to perform the duties required by section 256.9742.
HIST:1987 c 403 art 2 s 66

256.9741 DEFINITIONS.

Subdivision 1. "Long-term care facility" means a nursing home licensed under sections 144A.02 to 144A.10 or boarding care home licensed under sections 144.50 to 144.56.

Subd. 2. "Acute care facility" means a facility licensed